4742 04736

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 203

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A,15A - 5 - 53

1. PLACE OF DEATH: COUNTY Kent MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) OR TOWN Rock Hall. | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pennsylvania COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Philadelphia 75 X-3
STREET ADDRESS 2145 (If rural, give location) 66th Avenue

3. NAME OF DECEASED: (Type or Print) (First) Ida (Middle) P. (Last) Etter
4. DATE OF DEATH (Month) 5 (Day) 28 (Year) 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widow	8/Aug 2-1879	75 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Home wife	Home	Philadelphia Pa.	U.S.A.

13. FATHER'S NAME: Samuel Harvey
14. MOTHER'S MAIDEN NAME: Hannah Gill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No.		163-09-1768	Carroll T Schuch 2145—66 ave Phil Pa

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Multiple, severe injuries to chest and head	instantaneous
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Fractured skull	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY Yes ☐ No ☒
none		

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY Highway near	21c. (City or town) Rock Hall	(County) Kent	(State) Md.

21d. TIME OF INJURY (Month) 5 (Day) 28 (Year) 55 (Hour) 1:10 A.M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR? Automobile accident

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Robert W. Farr M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 5/28/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Wed June 1	Mt. Moriah	W Phil	Pa

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 28/55	S Elwood Burgess	Edgar L Lanier	Church Hill Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04737

1 4743

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:
COUNTY KENT MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WORTON
LENGTH OF STAY (in this place) LIFETIME
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD. COUNTY KENT
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WORTON
STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED: (First) SOPHIA (Middle) LOUISE (Last) GEARS

4. DATE OF DEATH: (Month) MAY (Day) 26 (Year) 1955

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. ~~SINGLE, MARRIED, WIDOWED, DIVORCED~~ (Specify): WIDOWED

8. DATE OF BIRTH: JULY 30, 1868

9. AGE last birthday: 86 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: NOAH HURD

14. MOTHER'S MAIDEN NAME: JANE MEEKINS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. NONE

17. INFORMANT & ADDRESS: PERRY GEARS CHESTERTOWN, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.0

IMMEDIATE CAUSE (A) Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: approx 1 yr.

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senility

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-27, 1954, to 5-21, 1955, that I last saw the deceased alive on 5-21, 1955, and that death occurred at 2½ A M, from the causes and on the date stated above.

SIGNATURE R. M. Atkins, M.D. ADDRESS Chestertown DATE SIGNED 5-26-55

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (SPECIFY) BURIAL | DATE THEREOF MAY 28, 1955. | NAME OF CEMETERY OR CREMATORY STILL POND CEMTY. | LOCATION (City, town, or county) (State) STILL POND, MD.

DATE REC'D BY LOCAL REGISTRAR 5/28/55 | REGISTRAR'S SIGNATURE E. Kenward Jones

24. FUNERAL DIRECTOR B. R. FELLOWS ADDRESS STILL POND, MD

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

04738

MARYLAND

STATE DEPARTMETT OF HEALTH

4744 CERTIFICATE OF DEATH

Reg. Dist. No. 202

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY KENT; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL CHESTERTOWN; LENGTH OF STAY (In this place) 8 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS QUAKER NECK

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY KENT; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL CHESTERTOWN; STREET ADDRESS (If rural, give location) QUAKER NECK 1

3. NAME OF DECEASED (Type or Print): (First) BRYCE (Middle) — (Last) GRAY

4. DATE OF DEATH: (Month) MAY (Day) 23 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify)

8. DATE OF BIRTH: APRIL 19, 1895

9. AGE last birthday: 60 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. ARMY

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED AIR FORCE

11. BIRTHPLACE (State or foreign country): NEW YORK

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: BRYCE GRAY

14. MOTHER'S MAIDEN NAME: ADA GWYNN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If year, give war or dates of service) WW I

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: WIFE – MRS BRYCE GRAY - CHESTERTOWN

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

Immediate cause (a) ARTERIOSCLEROTIC HEART DISEASE — Interval between onset and death: 10 yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. HYPERTERTENSIVE CARDIOVASCULAR DISEASE — 10 YRS

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JAN, 1952, to MAY 23, 1955, that I last saw the deceased alive on MAY 15, 1955, and that death occurred at 9:15 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) V.A. ADDRESS Chestertown, Md. DATE SIGNED 5-23-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE May 26 1955 — NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem. — LOCATION (City, town, or county) (State) Arlington Va.

DATE REC'D BY LOCAL REG. May 24-1955 — REGISTRAR'S SIGNATURE Clara S. Barnes.

24. FUNERAL DIRECTOR Marion V. Williams - Chestertown Md. — ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04739

4736

CERTIFICATE OF DEATH

Reg. Dist. No. 202

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Kent MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown
LENGTH OF STAY (in this place) 7 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 72 Kent and Queen Anne's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Queen Anne
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill 17X-2
STREET ADDRESS (If rural give location) Robert's Station ✓

3. NAME OF DECEASED: (Type or Print) (First) Thomas (Middle) B (Last) Kirby

4. DATE OF DEATH: (Month) May (Day) 10 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married
8. DATE OF BIRTH: June 18, 1879
9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin Kirby
14. MOTHER'S MAIDEN NAME: Mary E. Hunter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 9 (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 220-32-1439
17. INFORMANT & ADDRESS: Hopp. records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

181X
IMMEDIATE CAUSE (A) Generalized carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Carcinoma of bladder — 8 years
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 0
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-3- , 1955, to 5-10 , 1955 that I last saw the deceased alive on 5-10 , 1955, and that death occurred at 9:35 P.M. from the causes and on the date stated above.
SIGNATURE M. D. ADDRESS Chestertown, Md. DATE SIGNED 5-10-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF May 13-55
NAME OF CEMETERY OR CREMATORY Church Hill
LOCATION (City, town, or county) (State) Church Hill Md

DATE REC'D BY LOCAL REGISTRAR May 13-1955
REGISTRAR'S SIGNATURE Clara L. Barnes.
24. FUNERAL DIRECTOR Colon L. Lane ADDRESS Church Hill Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04741

4745

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH: COUNTY Kent MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Kent
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rock Hall
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) JAMES (Middle) ROBERT (Last) LEWIS

4. DATE OF DEATH: (Month) MAY (Day) 12 (Year) 1955

5. SEX: male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: Aug. 31 1882 | 9. AGE last birthday 72 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired merchant - Grocer | 10B. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John L. Lewis | 14. MOTHER'S MAIDEN NAME: Agnes Quail

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 9 (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS: Mrs. Ruth Sewell - Rock Hall, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

490X

IMMEDIATE CAUSE (A) Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSE (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Paralysis agitans — at least 10 years

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 0 | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1952, to May 12, 1955, that I last saw the deceased alive on May 11, 1955, and that death occurred at 6:45 AM, from the causes and on the date stated above.

SIGNATURE Willard F. Smith M.D. ADDRESS Rock Hall, Md DATE SIGNED 5/14/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF may 15 | NAME OF CEMETERY OR CREMATORY Wesley Chapel | LOCATION (City, town, or county) Rock Hall (State) Md.

DATE REC'D BY LOCAL REGISTRAR 5/14/55 | REGISTRAR'S SIGNATURE S. Elwood Burgess | 24. FUNERAL DIRECTOR Edgar L. Lane | ADDRESS: Church Hill, Md

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

04741

MARYLAND — **STATE DEPARTMENT OF HEALTH**

4746 CERTIFICATE OF DEATH

Reg. Dist. No. 223

Item 2, Film G181, 5/11/55 fcy

1. PLACE OF DEATH: COUNTY Kent — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rock Hall — LENGTH OF STAY (in this place) 5 Days — MARYLAND — HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Penna. — COUNTY — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Philadelphia 25 — STREET ADDRESS (If rural, give location) 839 E. Moyer St.

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) C. (Last) Markisch

4. DATE OF DEATH: (Month) May (Day) 1 (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Jan 14-1873

9. AGE last birthday: 82 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Phila Pa.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Christian Fielder

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17 INFORMANT AND ADDRESS: Mrs Adelaide Miller Rock Hall

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Possibly Coronary Thrombosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Heart — Coroner did not wish to come (c) Patient found dead in bed history of trouble

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. With Dr Albert R Rihl 2355 Susquehanna Ave Philadelphia

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... seen after death ....., 19..., to ....., 19 55, that I last saw the deceased alive on ..... Dead on arrival May 1, 19 55, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE E. Idell Ellis (Degree or title) — ADDRESS Rock Hall — DATE SIGNED May 1/55

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE: May 5-55 — NAME OF CEMETERY OR CREMATORY: Northwood — LOCATION (City, town, or county) (State): Phila Pa.

DATE REC'D BY LOCAL REG. May. 3/55 — REGISTRAR'S SIGNATURE: S. Elwood Burgess

24. FUNERAL DIRECTOR: Edgar L. Lane — ADDRESS: Church Hill Md.

MARGIN RESERVED FOR BINDING

4747 Iters 1,8,9 filed 82 c 2-55 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04742

CERTIFICATE OF DEATH

Reg. Dist. No. . . . . .

1. PLACE OF DEATH
COUNTY KENT MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural KENNEDYVILLE
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS (Kentmore Park)

2. USUAL RESIDENCE (HOME) OF DECEASED: X
STATE PENNA COUNTY DELAWARE
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WALLINGFORD; MEDIA P.O.
STREET ADDRESS (If rural give location) BALTIMORE PIKE

3. NAME OF DECEASED: (Type or Print) (First) HOWARD (Middle) RAYMOND (Last) MARPLE

4. DATE OF DEATH. (Month) 5 (Day) 24 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. ~~SINGLE, MARRIED, WIDOWED, DIVORCED~~ (Specify): MARRIED

8. DATE OF BIRTH: 6/24/02 6-2-99

9. AGE last birthday 16/2 55 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER

10B. KIND OF BUSINESS OR INDUSTRY: SALES ENGINEER

11. BIRTHPLACE (State or foreign country): PHILADELPHIA

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ANDREW B. MARPLE

14. MOTHER'S MAIDEN NAME: FRANCES CUNNINGHAM

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Helen Maxwell Marple - Media Pa.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 22, 1955, to May 24, 1955, that I last saw the deceased alive on May 22, 1955, and that death occurred at 11:45 P M, from the causes and on the date stated above.

SIGNATURE Florence Deringer Joyce M. D. ADDRESS WORTON, Md DATE SIGNED 5/25/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF May 27 1955

NAME OF CEMETERY OR CREMATORY West Laurel Hill Cem

LOCATION (City, town, or county) Phila. Pa. (State)

DATE REC'D BY LOCAL REGISTRAR 5/26/55

REGISTRAR'S SIGNATURE Elizabeth J. Mustard

24. FUNERAL DIRECTOR Edward Silber ADDRESS Millington Md.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4737

CERTIFICATE OF DEATH

04743

Reg. Dist. No. 202

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-53

1. PLACE OF DEATH:
COUNTY Kent MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 72 Kent & Queen Anne Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE N.J. COUNTY Camden
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Camden 67 X
STREET ADDRESS (If rural give location) 1171 Penn St ✓

3. NAME OF DECEASED: (Type or Print) (First) GLADYS (Middle) (Last) MILLER

4. DATE OF DEATH: (Month) May (Day) 1 (Year) 1955

5. SEX: F

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Separated

8. DATE OF BIRTH: 1/21/23

9. AGE last birthday: 32 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pressing

10B. KIND OF BUSINESS OR INDUSTRY: Factory

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Miller

14. MOTHER'S MAIDEN NAME: Sola Hansen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-16-6996

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

651.2 IMMEDIATE CAUSE

(A) Peritonitis and generalized sepsis due to

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) Ruptured uterus & criminal abortion due to performed on or about April 22, 1955

(C)

INTERVAL BETWEEN ONSET AND DEATH: about 1 week / same

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 5-1-55

19B. MAJOR FINDINGS OF OPERATION: Ruptured uterus - Profuse [illegible] of [illegible] in abdominal cavity & generalized peritonitis

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY occur?

22. I hereby certify that I attended the deceased from ... , 19.. , to , 19.. , that I last saw the deceased alive on 5-1 , 1955., and that death occurred at 5:45 PM, from the causes and on the date stated above.

SIGNATURE Robert N Farr, Deputy Medical Examiner, Kent County, M.D. ADDRESS Chestertown Md DATE SIGNED 5-1-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: 5/5/55

NAME OF CEMETERY OR CREMATORY: Pomona Cemetery

LOCATION (City, town, or county) (State): Pomona Maryland

DATE REC'D BY LOCAL REGISTRAR: May 5, 1955

REGISTRAR'S SIGNATURE: Clara S. Barnes / Brwynn

24. FUNERAL DIRECTOR: James B Dorsett Easton, Md.

ADDRESS

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04744

4738

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH. COUNTY Kent MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY KENT
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown; LENGTH OF STAY (in this place)	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS Kent & Queen Anne's	STREET ADDRESS (If rural give location) R.F.D #2
3. NAME OF DECEASED: (Type or Print) (First) Infant (Middle) (Last) Morris	4. DATE OF DEATH: (Month) May (Day) 7 (Year) 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W		May 7/1955				6	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): ~~USA~~ Maryland	12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wilbur H. Morris, Jr.

14. MOTHER'S MAIDEN NAME: Cecelia Elizabeth Redman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT & ADDRESS: Hosp. Records.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — 759.3 — IMMEDIATE CAUSE	(A) Shock, following operation	1/2 hour
ANTECEDENT CAUSE (S) — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) for congenital absence of anterior	6 hours
	DUE TO (C) wall with extrophy of abdominal organs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Hydrocephalus	

19A. DATE OF OPERATION: 5-7-55

19B. MAJOR FINDINGS OF OPERATION: Extrophy of abdominal organs, absence of anterior abdominal wall

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-7 1955, to 5-7, 1955, that I last saw the deceased alive on 5-7- ..., 1955, and that death occurred at 1:50 P.M. from the causes and on the date stated above.

SIGNATURE A.C. Fick M.D. ADDRESS Chestertown Md DATE SIGNED 5-8-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5/9/55	Chester~~xxxxxx~~.	Chestertown, Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
5/8/55	Clara S. Barnes	J. Willis Wells - Chestertown, Md.

22554-14

[illegible] V. S.

04745

MARYLAND

STATE DEPARTMETT OF HEALTH

4748

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH
COUNTY: Kent
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Rock Hall
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 00 Shaptim

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland. COUNTY: Kent
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rock Hall X
STREET ADDRESS (If rural, give location): Shaptim 1

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Etta (Last) Murray

4. DATE OF DEATH: (Month) May (Day) 7 (Year) 1955

5. SEX: F.

6. COLOR OR RACE: C.

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: apr. 1 1902

9. AGE last birthday: 53 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Canning

11. BIRTHPLACE (State or foreign country): Broad Neck, Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Douglas Johnson

14. MOTHER'S MAIDEN NAME: Carrie E. Sloan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

15. SOCIAL SECURITY No.: 215-26-3882

17. INFORMANT AND ADDRESS: Horace Murray - Rock Hall, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X
Immediate cause (a): Cerebral hemorrhage — Interval between onset and death: Immediate

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b): Hypertension, essential — years

(c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan ..., 1952, to May 7 ..., 1955, that I last saw the deceased alive on Jan ..., 1955, and that death occurred at 1 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Willard F. Smith MD ADDRESS: Rock Hall, Md. DATE SIGNED: 5/9/55

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: May. 10, 1955
NAME OF CEMETERY OR CREMATORY: Shaptown Cemetery
LOCATION (City, town, or county) (State): Rock Hall, Kent Co. Md.

DATE REC'D BY LOCAL REG.: May 10-55
REGISTRAR'S SIGNATURE: S. Elwood Bunyan

24. FUNERAL DIRECTOR: Wamin V. Williams - Centreville
ADDRESS: Md

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04746

4739

CERTIFICATE OF DEATH

Reg. Dist. No. 202

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY: Kent
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 37 Chestertown
LENGTH OF STAY (in this place): 42 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 72 Kent & Queen Ann's

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Kent
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown 37
STREET ADDRESS (If rural give location): Cannon Street 1

3. NAME OF DECEASED. (Type or Print): (First) Samuel (Middle) Harry (Last) Pfeffer

4. DATE OF DEATH: (Month) May (Day) 13 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: Sept. 8, 1859

9. AGE last birthday: 95 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boat captain

10B. KIND OF BUSINESS OR INDUSTRY: Shipping

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Pfeffer

14. MOTHER'S MAIDEN NAME: don't know

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT & ADDRESS: Hosp. records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE 450.0	(A) Infirmaties of old age	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Auricullar fibrillation	5 years
	DUE TO (C) Arteriosclerosis	5 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. , 1945, to May 13 , 1955 that I last saw the deceased alive on May 13 , 1955, and that death occurred at 9:20 M, from the causes and on the date stated above.

SIGNATURE: a'd Sick M. D.
ADDRESS: Chestertown, Md.
DATE SIGNED: 5-15-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: 5/16/55
NAME OF CEMETERY OR CREMATORY: Chester Cem.
LOCATION (City, town, or county) (State): Chestertown, Md.

DATE REC'D BY LOCAL REGISTRAR: May 16-1955
REGISTRAR'S SIGNATURE: Clara L. Barnes.

24. FUNERAL DIRECTOR: J. Willis Wells
ADDRESS: Chestertown, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04747

4740

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:
COUNTY KENT MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN
LENGTH OF STAY (in this place) 37
HOSPITAL OR INSTITUTION OR STREET ADDRESS KENT & QUEEN ANNE'S HOSPITAL 72

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD. COUNTY KENT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BETTERTON X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) ROBERT (Middle) N. (Last) RASH JR.

4. DATE OF DEATH: (Month) MAY (Day) 7, (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify): MARRIED

8. DATE OF BIRTH: AUG. 23, 1911

9. AGE last birthday: 43 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DRIVING

10B. KIND OF BUSINESS OR INDUSTRY: TRUCKING

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT N. RASH SR.

14. MOTHER'S MAIDEN NAME: BELLE WALBERT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-01-3454

17. INFORMANT & ADDRESS: MILDRED RASH, BETTERTON, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) VENTRICULAR FIBRILLATION — INTERVAL BETWEEN ONSET AND DEATH: 1 min

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) CORONARY OCCLUSION — 3 hrs

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: /

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 7, 1955, to May 7, 1955, that I last saw the deceased alive on May 7, 1955, and that death occurred at 1:50 P.M., from the causes and on the date stated above.

SIGNATURE Florence Deringer Joyce M.D. ADDRESS Worton DATE SIGNED May 8/1955

23. BURIAL, ~~CREMATION~~, REMOVAL (SPECIFY) BURIAL — DATE THEREOF MAY 10, 1955. — NAME OF CEMETERY OR CREMATORY STILL POND CEMTY — LOCATION (City, town, or county) STILL POND, (State) MD.

DATE REC'D BY LOCAL REGISTRAR 5/9/55 — REGISTRAR'S SIGNATURE E. Leonard Jones

24. FUNERAL DIRECTOR B.R. FELLOWS — ADDRESS STILL POND, MD.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

4741

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. 04748

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 202

1. PLACE OF DEATH:
COUNTY Kent MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Chestertown
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Kent and Queen Anne Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Kent
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rock Hall
STREET ADDRESS (If rural, give location) ~~Chestertown, Md.~~ Rock Hall

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) Ronald (Last) Taylor

4. DATE OF DEATH (Month) May (Day) 4 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: April 3, 1940

9. AGE last birthday: 15 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired): minor - Student

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Rock Hall, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Marion Eugene Taylor

14. MOTHER'S MAIDEN NAME: Hazel May Hatfield

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: M. Eugene Taylor, Rock Hall, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Fracture dislocation of the neck at the level of 3rd cervical vertabrae

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) DUE TO
(c) Automobile accident

INTERVAL BETWEEN ONSET AND DEATH: 1 hr. 7 mi

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None

19a. DATE OF OPERATION: none

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY

21c. (City or town) State Road 445, 2 miles S. Tolchester (County) (State) Maryland

21d. TIME OF INJURY (Month) 5 (Day) 5 (Year) 55 (Hour) 9:45 P.M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Automobile accident

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Robert W. Farr, M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 5/6/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: May, 7, 1955
NAME OF CEMETERY OR CREMATORY: Saint Paul Cemetery
LOCATION (City, town, or county) (State): near Fairlee Kent Co. Md.

DATE REC'D BY LOCAL REG. May 7, 1955
REGISTRAR'S SIGNATURE Clara S. Barnes
24. FUNERAL DIRECTOR Marvin V. Williams ADDRESS Marvin V. Williams, Chestertown, Md.

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04749

4749

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH: COUNTY KENT MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CHESTERTOWN RURAL
LENGTH OF STAY (in this place) 30 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 MRS. STRONG'S NURSING HOME

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD. COUNTY KENT
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WORTON RURAL X
STREET ADDRESS (If rural give location) (COLEMAN, MD.) 1

3. NAME OF DECEASED: (Type or Print) (First) HENRY (Middle) (Last) WYBLE

4. DATE OF DEATH: (Month) MAY (Day) 1 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify): MARRIED

8. DATE OF BIRTH: AUG. 23, 1880

9. AGE last birthday 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMING

10B. KIND OF BUSINESS OR INDUSTRY: FARM OWNER

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN WYBLE

14. MOTHER'S MAIDEN NAME: ELIZABETH GUYSER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. NONE

17. INFORMANT & ADDRESS: EUGENE H. WYBLE WORTON R.F.D. MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE (A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 15 min.

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Arteriosclerosis

DUE TO (C) Aging

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-1, 1955 to 5-1, 1955 that I last saw the deceased alive on 4-30, 1955, and that death occurred at 4:25 P M, from the causes and on the date stated above.

SIGNATURE L. M. Atkins, M. D. ADDRESS Chestertown DATE SIGNED 5-2-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL — DATE THEREOF MAY 4, 1955 — NAME OF CEMETERY OR CREMATORY STILL POND CEMTY — LOCATION (City, town, or county) (State) STILL POND, MD

DATE REC'D BY LOCAL REGISTRAR 5/3/55 — REGISTRAR'S SIGNATURE E. Kennard Jones

24. FUNERAL DIRECTOR B. R. FELLOWS — ADDRESS STILL POND, MD.

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.